

13-40
7-39
X23159

Registration District No. **399** **FILED OCT 11 1940** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Northeast Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days** (Specify whether years, months or days)
In this community **61 years**

3. (a) PRINT FULL NAME **SAMUEL SOLON KEYES**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harriet Elizabeth Keyes** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **June 16 1865**
(Month) (Day) (Year)

8. AGE: Years **75** Months **2** Days **14** If less than one day hr. min.

9. Birthplace **Wisconsin**
(City, town, or county) (State or foreign country)

10. Usual occupation **Operator**
11. Industry or business **Filling Station**

12. Name **No Record**

13. Birthplace **No Record**
(City, town, or county) (State or foreign country)

14. Maiden name **No Record**

15. Birthplace **No Record**
(City, town, or county) (State or foreign country)

16. (a) Informant **Earl R. Keyes**
(b) Address **4202 E. 31st St.**

17. (a) **Burial** (b) Date thereof **Sept 3-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **M. Wagner**
Kansas City, Mo.
(b) Address
19. (a) **Sept. 2, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **5016 East 8th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **31st**
year **1940** hour **12** minute **30** P. M.

21. I hereby certify that I attended the deceased from **August 31st** to **August 31st**, 1940, that I last saw him alive on **Aug 31st**, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial failure 3da**

Due to **Pneumonitis and hypertatic pulmonary congestion 5da**

Due to **Heart hypertrophy and failure 1**

Other conditions **Myocardial hypertrophy?**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration
3da
5da
2da
1
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? (e) Means of injury **2**

23. Signature **Eugene Wise** (M. D. or other) **MD**
Address **512 Royal Bldg** Date signed **8-31-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

120 -

Mr. White

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed: *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *K.C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 7 B
2-27-40
1222859

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2
Registrar's No. 3431

Registration District No. _____ Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Samuel S. Reyes
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ hr. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 912/40

19. (a) _____ (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month Aug Day 31 - 40
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial infarction
Peritonitis - Hypostatic
Pulm Congest.
Due to Acute nephritis / Chronic
Other conditions Cystitis
(Include pregnancy within 3 months of death)

Major findings: 131
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

5-30868